UNIVERSITY OF MARYLAND
SCHOOL OF LAW

November 22, 2011
(sent electronically)

Rebecca Pearce
Executive Director
Maryland Health Benefit Exchange
201 West Preston Street, 4th floor
Baltimore, Maryland 21201

RE: Recommendations to Health Benefit Exchange Board

Dear Ms. Pearce:

In response to your invitation for public comments made at the Health Benefit Exchange Board Meeting on November 15, 1022, the Drug Policy Clinic of the University of Maryland Carey School of Law is submitting the following comments and recommendations for your consideration. We have organized our comments to address some of the pathway questions posed by the November 15th Exchange Board presentation.

Pathways 1 and 6: Operating Model and Insurance Rules

1. Operating Model -- Selection Criteria

The Board will be assessing the benefits and risks of purchasing options for QHPs, including additional state selection criteria beyond the federal regulatory requirements. We recommend that the Exchange develop additional selection criteria as described in Option 2 of the Wakely Consulting Group Report, November 8, 2011 (p.16), and specifically establish requirements that QHPs meet comprehensive performance benchmarks, particularly performance goals relating to coordination of care, preventive care and managing chronic care. These items are particularly important to reduce the health and other costs associated with untreated substance use disorders. Such performance-based standards must be in place from the outset in order to be able to effectively monitor and assess the success of the Exchange in ensuring that QHPs deliver high quality healthcare to participants and reduce costs. Although the overt goals of the Exchange relate in large part to coverage issues, it is imperative for long-range sustainability that quality standards are in place to ensure that coverage translates into health care that meets the needs of the insured in a cost effective way.

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In addition we recommend that the Exchange be granted the flexibility to implement at any time additional rules either through certification standards or selective contracting as described in Options 3 and 4 of the Wakely Report (p. 16-17) to promote the goals of the exchange and to encourage innovation and cost effective health care delivery.

2. Essential Health Benefits

The Board will be assessing federal policy and regulations and determining whether the Exchange can or should move forward with making determinations on market rules, essential benefits and risk mitigation. We recommend that the Exchange move forward immediately to begin to develop a State definition of the Essential Health Benefit to submit for HHS approval as a State variation. Our recommendation is informed by the following considerations:

a. Alternative Definition. The IOM Report notes that the Secretary can grant a state-specific EHB variation request if the EHB is consistent with Section 1302 of the ACA, is actuarially equivalent to the federal EHB, and is a benefit plan that is supported by meaningful public input. (IOM Report at p. 8-3) The Maryland small employer benefit plan and the Maryland Medicaid benefit have been developed with substantial public input and reflect the cultural views and value judgments that exist in the State. Although the Comprehensive Standard Health Benefit Plan has limitations (notably a very high deductible, limited prescription drug benefit, and excessive cost-sharing for the mental health and substance used disorder benefit and day limitations for inpatient care that are not in parity with somatic health services), it should serve as the benchmark for the Maryland EHB, and any adjustments that need to be made in order to meet the federal actuarial limit should be considered and determined by the Exchange in reference to the history and culture of insurance and health delivery in Maryland. The State should move ahead now to costing and prioritizing its small employer benefit in order to create a State alternative that can be quickly adjusted to fit the federal EHB actuarial limit and approved in time for implementation in 2014.

b. Maryland's Mental Health and Substance Use Disorder Treatment. The IOM Report has noted that certain of the 10 ACA mandated benefits, including mental health and substance use disorder treatment, have not been adequately incorporated into most small employer package and HHS must look to Medicaid plans and to States that have a developed comprehensive benefit package for those underrepresented benefits (IOM at p. 5-3). Maryland is one of the States that has more comprehensive mental health/substance use disorder coverage in both its small employer plans (albeit with excessive cost sharing and lack of parity) and Medicaid programs and these plans will serve as guideposts for HHS for inclusion of these underrepresented benefits. Maryland should use its own experience with mental health and addiction treatment coverage to develop the appropriate essential benefit in those areas. Maryland has sufficient experience to cost-out these benefits and can look to other States, such as Oregon, to begin to prioritize the full essential benefit package.

c. Evaluating Current State Mandates. The Mercer Report on Market Rules and Risk Selection (November 8, 2011), includes some preliminary analysis of costs associated with specific state mandates.[1] Presentations made by the Mercer consultants to the Advisory Committee noted that mental health and substance use disorder benefit may be one of the highest cost mandates most

[1] We also note that the Mercer description of the mental health/substance use disorder benefit under the Comprehensive Standard Health Benefit Plan does not fully describe the benefit. Under COMAR §31.11.06.03G, partial hospitalization is also available with two partial hospitalization days being substituted for one inpatient day in a hospital or related institution.

susceptible to reduction. We submit that a state mandate, especially a mandate such as mental health and substance use disorder treatment that is one of the 10 ACA mandated benefit, ***should not*** be targeted for reduction simply because it represents a higher proportion of total cost in relation to other mandates (and, indeed, limitations imposed by high cost-sharing and days in treatment must be addressed). Reductions in substance use disorder treatment, for example, may well increase costs of all other medical care. Research shows that comprehensive addiction treatment, including prevention, outpatient, inpatient and recovery supports, is cost effective, pays for itself in reductions in other more costly services, and consistently results in savings overall in total health care costs. Research and experience should inform decisions on how to structure or restructure benefits to achieve the highest cost benefit for the State.

Pathway 2: SHOP

1. Merger of Individual and Small Group and Expansion to 100 Employees Before 2016.

One of the driving principles in establishing a successful Exchange is to create a very large pool of participants who have average risk. Insurance carriers will not ignore a large, average risk market and will likely present competitive bids for premiums. (*See* David Riemer and Alain Enthoven, The Only Public Health Plan We Need, THE NEW YORK TIMES (JUNE 24, 2009), available at http://www.nytimes.com/2009/06/25/opinion/25enthoven.html.) The Institute for Health Policy Solutions' SHOP Exchange Report affirms that the projected size of the respective exchanges is a key factor in determining whether to merge the individual and SHOP Exchanges and/or implement the 100 employee definition of small employer in 2014. IHPS suggests that the merger of the individual and SHOP exchanges and expansion to 100 employees prior to 2016 is not needed to achieve sustainability since each exchange standing alone would be large enough in size to meet the "critical mass" required to spread risk and be stable over time. (Analysis of Key Maryland SHOP-Related Policy Options at 5 and 15). We recognize that additional analysis is needed to develop more realistic estimates of the participant pools and determine the impact of merger on premium costs.

At the same time, we urge the State to carefully consider all design features from the outset that will: (1) ensure the largest, average risk pool possible; (2) attract new carriers to Maryland largely through market forces that should respond to the size of the pool; (3) ensure the greatest amount of competition among carriers, including the nurturing of regional carriers that could effectively serve different parts of the state; and (4) reduce administrative costs associated with operating two separate exchanges. Postponing the implementation of certain critical decisions can adversely affect rather than promote affordability, stability and sustainability.

There also appear to be very good reasons to implement the small employer 100 employee definition in 2014 rather than 2016. As outlined by IHPS, this change is inevitable and early implementation will eliminate a second round of disruption in the market (just as stability is being achieved). This would undoubtedly increase the size of the small employer pool and attract new carriers to the market with the potential of greater competition and cost savings to employers and employees. In addition, employees would likely have a greater range of choices in health plans and experience less disruption in coverage and provider relationships when changing jobs. (SHOP-Related Policy Options at 19).

2. IT System

Comments submitted by the Women's Coalition for Health Care Reform have drawn our attention to the IT system that will be the glue of the State's health care reform implementation efforts. We share the Women's Coalition's concern about establishing separate IT systems for the individual and SHOP exchanges. As noted by the Women's Coalition, an integrated system seems best positioned to ensure that consumers will not be required to operate in different IT systems as they move from public insurance to a subsidized QHP to small employer coverage. A singular system would also seem to promote more efficient and consistent data collection and oversight. In addition, to the extent the individual and SHOP Exchange are merged in the near future, tremendous resources will have been wasted on the implementation of a separate SHOP IT system and the existence of a separate IT system could affect the willingness to move to a merger.

In addition, the IT system will be a critical tool in facilitating enrollment. We urge that special attention be given to the needs of individuals with low literacy and cognitive impairments in the development of the web portal. Interactive programs will assist these individuals as they navigate the system.

Pathway 4: Navigator and Enrollment

1. Individual and SHOP Navigator Program Features

The Navigator programs should be structured to reach all uninsured individuals through trusted entities in the community. Those entities will differ across populations, and solid market research specific to Maryland's uninsured population should identify the most appropriate points of contact (whether those are faith-based institutions, health care providers, peer support and criminal justice re-entry groups, educational and adult learning institutions, informal business networks, gyms and community sports leagues).

Community-based organizations, including substance use disorder treatment programs, that have existing relationships with enrolling low-income, hard-to-reach populations in public health insurance and other benefit plans should be encouraged to develop partnerships to fulfill the Navigator role. As a part of those teams, lead organizations should engage outreach and education specialists that include persons from the target population (i.e. formerly homeless persons, persons with mental health and addiction histories). The community-based Navigators should also evaluate their target audience's need for post-enrollment support and consumer assistance. Although Navigator resources should certainly focus primarily on outreach and enrollment, previously uninsured individuals will likely need assistance post-enrollment to address claims and other problems. Just as the SHOP Exchange will factor this post-enrollment support into its operation and cost, equity across the two Exchanges would demand comparable support to individual enrollees. Many would be best served by a single entity that has assisted the individual with enrollment, and this may be an effective way to sustain enrollment.

Data on the actual cost of the various navigator functions is needed to accurately price these services. Funding for individual and SHOP Navigators, to the extent separate Navigator systems are established for the short or long term, must be on par and must be sufficient to ensure effective services and optimal enrollment.

2. Integration of Individual Navigator Program with Medicaid Outreach and Enrollment

The Medicaid broker and enrollment functions should be rolled into the Navigator function with the Exchange serving as a single portal for all applications and enrollment. Medicaid funding could support the enrollment services for this population through the Exchange.

3. Training Requirements

Regardless of the Navigator model for the individual and SHOP exchanges, training should be standardized to address eligibility and enrollment for the public (Medicaid, MCHIP) and commercial insurance programs, eligibility for premium tax credits and cost-sharing reductions. This foundational training will ensure that all individuals receive reliable information about their insurance options regardless of the entry point and could reduce the cost of training. Specialized training will be required for persons who are providing information on more complex tax-related issues to ensure, among other things, that enrollees are not subject to repayment of tax liability.

In addition, training must develop skill sets in how to communicate, in a culturally appropriate way, about health care needs and financial constraints to best assist in plan selection. Most individuals and families have unique health considerations that should be ascertained and evaluated in the plan selection process. Communication skills must also focus on cognitive and educational barriers that some low-income individuals will present. Training must also include education relating to the confidentiality of client health information, particularly sensitive health information including that related to substance use disorder and mental health care.

4. Enrolling Hard-to-Reach Populations in Medicaid and QHPs

The Navigator system will be positioned to reach some of the hardest to reach populations through networks/partnerships of community-based programs that have existing relationships within communities and are trusted by consumers and the service providers they generally rely upon. One population that the Navigator program should focus special attention on is individuals who are exiting the criminal justice system. These individuals have poorer health than the general public and a high incidence of mental health and substance use disorders and other chronic health conditions. The State can realize savings in both health and criminal justice costs by ensuring that inmates are enrolled in a health plan prior to release from prisons and jails. (*See* Joseph P. Morrissey, National Institute of Justice, MEDICAID BENEFITS AND RECIDIVISM OF MENTALLY ILL PERSONS RELEASED FROM JAIL (2004) available at

http://www.ncjrs.gov/pdffiles1/nij/grants/214169.pdf.) As a literally "captive" audience, the Navigator program should work with the Department of Corrections and Medicaid to ensure that all persons are enrolled in a Medicaid plan and linked with a primary care provider and other specialty care prior to release. To the extent an inmate is eligible for a QHP (apart from his or her incarceration status), all steps short of actual enrollment must be taken prior to release so that coverage may be put into effect on the day of release.

Thank you again for the opportunity to comment and for the open process of review and the opportunity for public participation that has characterized the months of thoughtful evaluation and consideration of the most optimal Exchange model for Marylanders. We are happy to answer any follow-up questions on our comments and in particular on any issues that may impact the access and scope of addiction treatment services under the QHPs in the Exchange.

Sincerely,

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